



Fairfax County Office for Children

School Age Child Care

12011 Government Center Pkwy., Suite 936, Fairfax, VA 22035

Phone: 703-449-8989 • Fax: 703-653-1304

www.fairfaxcounty.gov/ofc

FINANCIAL INFORMATION FORM

Mother's Name: _____ Father's Name: _____

Guardian/Contributing Household Member (Name & Relationship): _____

Child(ren)'s Name(s): _____ Home Phone #: _____

Work Phone (Mother): _____ Work Phone (Father): _____

Cell Phone (Mother): _____ Cell Phone (Father): _____

Billing Address: _____ SACC Account #: _____

Email Address: _____ SACC Center Name: _____

Household Income Information

	(Check one)	Per Pay Period (gross)	Gross Annual Total
<u>Mother's/Guardian's Salary</u>	weekly bi-weekly bi-monthly monthly	\$ _____	\$ _____
<u>Father's/Guardian's Salary</u>	weekly bi-weekly bi-monthly monthly	\$ _____	\$ _____
<u>Alimony/Child Support</u>	weekly bi-weekly bi-monthly monthly	\$ _____	\$ _____
<u>Other Income</u> (please explain)			\$ _____
Gross Annual Household Total		(line 1)	\$ _____
Deductions			
Number of children under the age of 18 in the household x \$4,000		(line 2)	(-) \$ _____
Adjusted Household Income		(line 1 minus line 2)	(=) \$ _____

I certify that the above income information is a true and accurate statement of the financial status and composition of my household. I understand that giving inaccurate or erroneous information may result in loss of eligibility for reduced fees. I will notify SACC Registration within 10 days if there is any change in the information provided. I understand that any fee reduction resulting from changes in the household income information will become effective from the point of receipt forward, and will not be retroactive.

Parent/Guardian Signature _____ Date _____



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Family Services

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Reasonable accommodations made upon
request; call 703-449-1414 or TTY 711.

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